TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Endsley, Ferral Lee

Respondent Name
Great Midwest Insurance Co

MFDR Tracking Number
M4-16-0822-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier received notice of the injury on 7/31/15, however the date of the "notice of dispute" is 9/11/15 which is 6 weeks after they received the notice. Per TAC 124.3, they should be responsible for the medical bills."

Amount in Dispute: $109.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on November 30, 2015. The insurance carrier did not submit a response for consideration in this review. Per 28 Texas Administrative Code §133.307(d)(1), "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2015	99213	$109.51	$109.51

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §124.3 sets out requirements for notice of denial/dispute.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - TTP4 – Workers compensation claim adjudicated as non compensable
   - TX P12 – Workers' compensation jurisdictional fee schedule adjustment
   - GN01 – This is a contested claim. The Defendant denies that any injury or need for treatment arose out of or occurred within the course and scope of the injured work's employment.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule that applies to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codeGN01 – "This is a contested claim." 28 Texas Administrative Code §124.3 (a) states,

> Except as provided in subsection (b) of this section, upon receipt of written notice of injury as provided in §124.1 of this title (relating to Notice of Injury) the carrier shall conduct an investigation relating to the compensability of the injury, the carrier's liability for the injury, and the accrual of benefits. If the carrier believes that it is not liable for the injury or that the injury was not compensable, the carrier shall file the notice of denial of a claim (notice of denial) in the form and manner required by §124.2 of this title (relating to Carrier Reporting and Notification Requirements).
>
> (2) If the carrier files a notice of denial after the 15th day but on or before the 60th day after receipt of written notice of the injury:
>
> (A) The insurance carrier is liable for and shall pay all income benefits that had accrued and were payable prior to the date the carrier filed the notice of denial and only then is it permitted to suspend payment of benefits; and
>
> (B) The insurance carrier is liable for and shall pay for all medical services, in accordance with the Act and rules, provided prior to the filing of the notice of denial.

Review of the submitted documentation finds:

- Date injury reported to Claim Administrator 07/31/2015
- Date of Notice of Denial September 11, 2015

This date is greater than the 15th day but before the 60th day. Pursuant to the above the services in dispute will be reviewed per applicable fee guidelines.

2. 28 Texas Administrative Code 134.203(c) states,

> To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
>
> (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The maximum allowable reimbursement is calculated as follows: (DWC Conversion Factor / Medicare Conversion Factor) x Participating Amount = Tx Fee MAR or (56.2 / 35.7547) x $70.02 = $110.06

3. The total allowable for the service in dispute is $110.06. The requestor is seeking $109.51. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $109.51.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $109.51 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		February 2, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.